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F 000	INITIAL COMMENTS An onsite complaint investigation was conducted on 9/24/24 through 9/25/24. Event ID: GRP511. Additional information was obtained off site for the extended survey on 09/27/24. Therefore, the exit date was changed to 9/27/24. The following intakes were investigated NC00221718 and NC00222235. One of the 2 complaint allegations resulted in deficiency. Intake NC00222235 resulted in immediate jeopardy. Past noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity J. The tag F689 constituted Substandard Quality of Care. Immediate jeopardy began on 9/18/24 and the facility came back into compliance effective 9/20/24. A partial extended survey was conducted.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff, Law Enforcement Officer and Medical Director	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/08/2024

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(MD) interviews, the facility failed to supervise a cognitively impaired resident from exiting the locked memory care unit of the facility unsupervised without staff knowledge for 1 of 2 residents reviewed for accidents (Resident #1). Resident #1 went through the adjoining bathroom to the neighboring room and removed a windowpane and exited through the window. Resident #1 walked approximately 2/10 mile after dark on a two-lane street with streetlights and no sidewalk. He was wearing pants, shirt, jacket, and shoes. Resident #1 was found across the three-lane road from the gas station/convenience store by a staff member. He was transported back to the facility by a law enforcement officer. There was the high likelihood of a serious adverse outcome for Resident #1 when he removed the heavy glass windowpane, exited through the window which was 79 inches from the ground, and walked unsupervised to the gas station/convenience store.

Findings included:

Resident #1, a 59-year-old male, was admitted to the facility on 7/25/22 with diagnoses which included Alzheimer's disease, dementia, aphasia, anxiety, tobacco use and history of stroke.

Resident #1's annual Minimum Data Set (MDS) dated 8/02/24 revealed he had moderately impaired cognition and his speech was unclear. Resident #1 was usually understood and usually understood by others. He exhibited no wandering behaviors during the lookback period (7 days prior to the MDS date). He was independent for walking at least 150 feet. Resident #1 did not utilize a mobility device and did not use a wander/elopement alarm. He was 74 inches tall

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and weighed 200 pounds. Resident #1 had verbal behavioral symptoms directed toward others 1-3 days during the lookback period (7 days prior to MDS date). Resident #1 had no range of motion impairment in his upper or lower extremities and was independent with transfers.

Resident #1's elopement assessment dated 6/26/24 revealed he had no history of attempted elopement or actual elopement.

Resident #1's care plan last revised on 8/02/24 had a focus which read in part the resident is at risk for elopement related to confusion. Interventions included to encourage resident's participation in activity preferences, divert resident by giving alternative objects or activities, and listen to resident and try to calm. Resident #1's care plan had another focus related to impaired communication with resident usually understood and usually understands and does have diagnosis of aphasia (Aphasia is a brain disorder where a person has trouble speaking or understanding other people speaking). Interventions included that resident does use gestures and nods yes or no, repeat answers to verify what you understood was correct, and allow sufficient time for resident to process and respond.

The Weather Underground website revealed the outdoor air temperature where the facility was located on 9/18/24 at 11:54 PM was 69 degrees F with no precipitation.

Nurse's progress note dated 9/19/24 at 1:00 AM written by Nurse #1 read in part that the resident had an event that warranted the MD notification. The Resident was ordered Ativan (an antianxiety

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medication) 1 milligram by mouth immediately. He was agitated, cursing, but calmed down and took the medication. Resident placed on 1:1 with a Nursing Assistant.

An interview on 9/24/24 at 3:02 PM with Nurse #1 revealed she was the nurse assigned to Resident #1 on the night shift of 9/18/24. She stated she saw the resident between 10:00 PM and 10:17 PM when he was gesturing to go outside to smoke. Nurse #1 stated the resident was told they were in the middle of putting some other residents to bed and she was completing her medication pass and they were unable to take him outside at that time. Nurse #1 indicated Resident #1 went to his room and she and the other staff continued to provide care for other residents. Nurse #1 observed the resident wearing pajama pants, t-shirt, and was barefoot when she saw him on the unit between 10:00 PM and 10:17 PM. Then Nursing Assistant (NA) #1 informed her around 11:30 PM that Resident #1 was not in his room or his bathroom. Nurse #1 went to Resident #1's room (Room 411), and the resident was not in his room or bathroom. Nurse #1 indicated she went to the next room (Room 409) and saw a windowpane leaning up against the empty bed by the window. She directed staff to continue searching the facility and outside around the facility. Nurse #1 initiated the facility's missing resident/elopement procedure and called the police to notify them of the resident's elopement and then notified the facility Administrator and the on-call Department of Social Services employee. Resident #1 was located at a convenience store/gas station 2/10 mile from the facility by a staff member. The police went to the gas station and transported Resident #1 back to the facility around midnight.

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Nurse #1 explained Resident #1 was agitated when he returned, and she contacted the on-call physician for an order for medication to help with his agitation. Resident #1 was also placed on 1:1 observation. Resident #1 initially refused a skin check but later let her complete a skin check and vital signs where she noted no injuries or abnormalities.

An interview on 9/24/24 at 4:05 PM with Nurse #2 revealed she was in the facility on night shift on 9/18/24 when Resident #1 eloped out the locked memory care unit window. Nurse #2 stated she was assigned to another unit at the facility, but when she became aware of the resident's elopement, she got into her personal vehicle and drove around the neighborhood to look for the resident. Nurse #2 further stated she went to the closest convenience gas station and asked the store clerk if they had seen anyone with Resident #1's description. The clerk indicated that someone matching Resident #1's description had been in the store twice, once to buy cigarettes and once to buy a drink. Nurse #2 stated she walked back out of the store and observed Resident #1 across the street. She called out to Resident #1, and he walked over to her. Resident #1 refused to get in her car, but the police were able to get him to ride in their car back to the facility. Nurse #2 stated Resident #1 was wearing pajama pants, white t-shirt, light jacket and shoes.

An interview on 9/24/244 at 8:02 PM with Law Enforcement Officer #1 revealed he responded to Resident #1's elopement from the facility. He stated Resident #1 was located at a convenience store/gas station and was transported back to the facility. The interview further revealed Law

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Enforcement Officer #1 along with 2 other officers, put the windowpane back into the frame.

An interview on 9/24/24 at 3:37 PM with Nursing Assistant (NA) #1 revealed he was working on the memory care unit the night shift of 9/18/24 when Resident #1 eloped. He stated that around 10:00 PM, Resident #1 wanted to go outside to smoke, but was told a staff member would take him out after they made rounds to provide care for some other residents. NA #1 went to check on Resident #1 around 11:30 PM and couldn't find him in his room or bathroom. NA #1 notified Nurse #1, and they started looking for the resident. NA #1 stated he did not remember what Resident #1 was wearing but noted he was wearing shoes when the officer brought him back to the unit. He stated after the resident was returned to the unit; he was assigned to provide 1:1 care for him the rest of his shift.

Review of the Sparta Police Department incident report dated 9/18/24 at 11:37 PM read in part that Law Enforcement Officer #1 was dispatched to the facility at approximately 11:40 PM and arrived at the facility at 11:41 PM. Resident #1 was found by Nurse #2 at approximately 11:57 PM and Law Enforcement Officer #1 went to the convenience store and transported the resident back to the facility. Several officers assisted with putting the window back in place and then left the scene.

An interview on 9/24/24 at 1:20 PM with the Administrator revealed she was notified of Resident #1's elopement on 9/18/24 at 11:40 PM. She arrived at the facility around midnight and the police had already brought Resident #1 back. The Administrator stated they were already in the process of transferring the resident to another

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facility to be closer to his guardian and family and he was transferred to another facility on 9/20/24 which had an interior courtyard where the resident could smoke. Resident #1 was placed on 1:1 observation from the time he returned to the facility until he was transported to his new facility. The Administrator indicated all staff were in-serviced on the resident elopement policy and process. All residents were evaluated for their physical capabilities, behaviors, and wandering to assess whether they could remove a windowpane. The Administrator further stated all new admissions would be evaluated for their ability to remove the windowpanes.

An interview on 9/25/24 at 8:40 AM with the Medical Director revealed he was notified of Resident #1's elopement 9/19/24. The Medical Director stated that he did not see how anyone could have anticipated that the resident would be able to remove a windowpane, and he had never heard of that happening before. The interview further revealed given Resident #1's diagnoses and the fact that he was in a locked memory care unit, it was not safe for him to be out of the facility unsupervised.

An observation and interview on 9/24/24 at 11:43 AM with the Maintenance Director revealed that the window had 2 panes and measured 70 x 45 inches total. The right side of the window slid to the left side on a track. The left side of the track had a screw affixed to the bottom of the track to prevent the window from opening more than 6 and 5/8 inches. There was no screen in the window. The window in Room 409 was 79 inches from the grass/ground outside. The Maintenance Director stated that he had been employed at the facility about 4 months and had completed a

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window audit in July to ensure that all the windows had a screw in the bottom track to prevent it from opening more than 7 inches. He also stated that the right windowpane was physically removed from the track by Resident #1. He did not know how Resident #1 was able to remove the windowpane. The Maintenance Director noted he had completed another window audit on 9/19/24 to ensure all the windows had a screw in the bottom track.

An interview on 9/25/24 at 11:17 AM with the Director of Plant Operations revealed he had been the Maintenance Director at the facility for several years. The Director of Plant Operations stated he had looked at the window in Room 409 where Resident #1 removed the windowpane on 9/19/24 and did not know how the resident got the windowpane out.

An observation on 9/24/24 at 5:00 PM with the Administrator revealed from the facility to the convenience gas station was about 2/10 mile through the back parking lot, service area, and two neighborhood roads. There were streetlights observed on the two neighborhood roads. These roads were wide enough for 2 cars but had no painted lines or sidewalks. There were no posted speed limit signs. The convenience store/gas station was across the street at the end of the neighborhood road. The street the convenience gas station was located on was three lanes (middle turn lane) with painted lanes and streetlights. The posted speed limit sign was 20 miles per hour.

An additional observation on 9/25/24 at 11:00 AM of the window in Room 409 revealed there were four 2-inch scratch marks about ¼ inch deep on

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the window casement as well as a black scuff mark. The caulking was in place around the window frame. The Maintenance Director and the Administrator were present during the observation and reiterated they had no idea how Resident #1 was able to remove the windowpane to exit the facility.

The Administrator was notified of the immediate jeopardy on 9/25/24 at 12:53 PM.

The facility provided the following corrective action plan with a completion date of 9/20/24.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

Resident #1 is a 59-year-old male admitted to the facility on 7/25/22. Resident #1 was admitted with a diagnosis of but not limited to unspecified injury of the head, aphasia, unspecified mood disorder and unspecified dementia.

Resident does not have history of previous elopements Resident #1 is a smoker. Resident was admitted on the secured unit secondary to having diagnosis of unspecified dementia and ability to ambulate.

On 9/18/24 approximately at 10:30 PM Resident #1 requested facility staff to have a smoke break. Facility staff addressed Resident #1 letting him know that it would be a little bit as he had just had a smoke, and staff were providing resident care. Resident #1 returned to his room and closed the door as he normally would. Resident #1 showed no signs of being upset or agitated and returned

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to his room as he normally would, closing the door behind him. This was normal behavior for Resident #1. While conducting rounds at approximately 11:40 PM staff identified that Resident #1 was not in his room. This alerted the staff to begin looking in other rooms and do a general sweep of the area. It was also identified that the windowpane in the adjoining room had been removed and placed on the floor. Facility staff immediately began systematic procedures for "missing resident" and notifying the Administrator, and Police Department. Nurse Aides and Nurse #1 began facility sweep while Nurse #2 went to her vehicle and began driving around surrounding areas in search of Resident #1. Nurse #2 drove to the only 24-hour business in the area which was a nearby gas station. Nurse #2 entered the gas station and provided the clerk with a description of Resident #1. The clerk stated that the resident had been in the gas station and purchased a soda and pack of cigarettes. Nurse #2 exited the gas station and began looking in the area when she saw Resident #1 on the sidewalk in front of the store and called his name. Resident #1 began walking towards Nurse #2. At this time the police arrived on the scene and Resident #1 agreed to return to the facility and chose to ride with the police officer. Upon arrival back at the facility a skin assessment was completed on Resident #1 and no issues were identified. Vital signs were also recorded for the resident by Nurse #1. Resident #1 was placed on 1:1 supervision. Three of the responding police officers were able to work together and put the windowpane back into place. The on-call provider and guardian were notified of the event.

The center had previously been seeking

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alternative placement for the resident months prior to the event.

Requirements for that location were that the new facility needed to be more proximal to the guardian's location and offer smoking. Arrangements were finalized earlier that evening prior to the event and communicated by the Administrator to the guardian. Arrangements were agreed upon and discharge was set for 9/20/2024. Post the event there was a discussion with the guardian and a new location was proposed. This facility differed from the original proposal because the structure of the center was a single level facility with an interior smoking area. Once discussed with the guardian, arrangements were made for the resident to be discharged there on 9/20/2024. Resident discharge as planned on 9/20/2024 with no adversity.

The Director of Nursing, Administrator, and the attending nurse discussed the root cause and determined Resident #1's request to smoke was declined, and he went to his room while unsupervised. Resident #1 then went through an adjoining bathroom and removed a windowpane in the neighboring room and exited through the window.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice
Residents currently residing in the facility have the potential to be affected.

On 9/19/24 the Director of Nursing assessed current residents for ability to walk, cognitive impairment, ability to reasonably remove a

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windowpane and climb through the window opening. No residents were identified at risk during the assessment. During the investigation, a review of residents who pose as a potential elopement based on exit seeking behaviors and abilities to exit were assessed with no additional residents identified. All residents have open utilization data assessment (UDA) named "elopement assessments" scheduled for their Admission/ Quarterly, these assessments are completed by floor nursing.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

The Maintenance Director conducted a house audit of windows to ensure that windows could not open greater than 7 inches on 9/19/24. Any window that indicated the ability to exceed the limit, or seemed defective was addressed and additional hardware such as additional screws were put into place. Center utilizes a keypad system on each of the exit doors. Each door has a different code and are frequently changes to prevent residents from exiting.

On 9/19/24 the Maintenance Director reviewed the affected window and was unable to identify any deficits of the window, causing it to be easily removed. Screw was in place and there was no damage sustained to the glass or the tracks of the window. Maintenance Supervisor did replace a weather type seal of the window, but this was not part of the operations of the window. Window was found to not be defective.

An interview with the Regional Maintenance Director took place on 9/19/24 at 10:31PM.

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Results from that indicated that the frames of the windows were not removeable and was part of the structure of the building, which is composited of brick and mortar. The windowpanes do have less than a ¼ inch space around them for expansion. The windows will continue to be assessed for any malfunction or age-related faults.

The facility is equipped with door locks/alarms, keypad systems and wanderguards to help avoid elopements. These mechanisms were checked by the center's Maintenance Director on 9/19/24. The Wanderguard system and door monitoring system were also audited by the Maintenance Director on 9/19/24. Results from the audits indicated that all systems were operable.

The education on the center's Elopement and Wandering Policy was initiated on 9/19/24 by the Administrator and carried on by the Unit Manager. All staff in Nursing, Agency, Therapy, Housekeeping, Administration, and Dietary have received education verbally or in-person prior to working. Education was provided face to face for individuals who were on shift, others not on-site were provided with education via phone. Those who received education via phone will be expected to sign the education prior to working next shift. The education included ensuring residents that exhibit exit seeking behaviors and/or at risk for elopement receive adequate supervision to prevent accidents in the facility's control. Staff were educated on how to identify exit seeking behaviors, monitor the affected resident, and interventions. Education highlighted that alarms doesn't replace the necessary supervision of a resident. Nor does it negate how vigilant that the staff should be in responding to

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	345261	A. BUILDING _____ B. WING _____	C 09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION	179 COMBS STREET SPARTA, NC 28675

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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alarms or actions of the resident that would indicate an elopement risk. Staff were instructed that if they were to witness a resident attempting to open a door or window, he / she should make efforts to remove the resident from the area through redirection and should never stop monitoring the resident. Once resident is safe the attending nurse should immediately notify the Nurse Leadership for interventions and make sure that a new elopement assessment is completed. Behaviors that indicate a risk for elopement of a resident should be communicated in report between staff and added to the elopement binder, which will be maintained by the Social Worker. The elopement binder was updated by the DON on 9/19/24. The elopement binder will be maintained moving forward by the Social Worker. The Social Worker was notified of this responsibility on 9/19/24. Staff were reminded that elopement binders are located at each Nurses Station and in the Social Worker's office.

Education will be oversighted by DON, anyone not educated on 9/19/24 will need to be educated in- person prior to shift by the Unit Manger / DON. Both the Unit Manager and DON have been educated on their responsibilities effective 9/19/24

Newly hired staff members will receive education in orientation from the Director of Nursing and/or Maintenance Director on the day of orientation it is also during that time that staff will be educated on how to identify behaviors that will trigger a new elopement risk assessment to be completed.

On 9/19/24 the Administrator implemented the Director of Nursing or Unit Manager would be responsible for conducting the elopement

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assessments on new admissions. Residents will be assessed for risk of elopement and unsafe wandering throughout their stay by the interdisciplinary care plan team. The Director of Nursing and Unit Manager have been educated by the Therapy Director on how to assess residents who are at risk exiting through a window and via the door. Assessments will take into consideration a resident; mobility, cognition, dexterity, and ability to balance bi-laterally. Both DON and Unit Manger have been made aware of the responsibility and comprehensively assess and complete the elopement risk UDA for each resident.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

Audits were put into place on 9/19/24, the Maintenance Director will audit two times a week for 12 weeks to ensure that the residents' windows do not have any defective or bent areas that keeps them secured. Any defective item will be corrected immediately. While repair is being completed the window will have constant monitoring by a facility staff member.

Audits will also consist of the responsiveness and demonstration from the staff to properly execute procedures outlined in the Elopement and Wandering Residents Policy. Random audits of the center's response to elopement drills will be completed 1 time a week for 12 weeks by the Maintenance Director or Administrator.
Weekly assessment of the wanderguard system by the Maintenance Director will continue regularly thereafter.

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ADHOC QAPI was initiated by the IDT team about the event on 9/19/24. The Administrator directed the Director of Nursing and Maintenance Director on 9/19/24 that they are responsible for forwarding the results of their audits the QAPI Committee monthly for three months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.

Completion date: 9/20/24

The corrective action plan of immediate jeopardy removal was validated on 9/25/24. Interviews were conducted with a sample of Nursing Assistants, Nurses, Director of Nursing, Unit Manager, and the Maintenance Director to verify education was conducted for elopement and wandering residents. Review of sign-in sheets confirmed all staff in departments received education regarding elopement and wandering residents.

Review of audits revealed the twice weekly window audits were completed (9/19/24 and 9/24/24). Further review of audits revealed weekly wander guard assessments including doors, locks and alarm systems were completed on 9/19/24 and 9/23/24.

An interview with the Unit Manager on 9/24/24 at 9:00 AM revealed she had received education about resident elopement and assessment of current and new residents for elopement risks. She will assess new admission for elopement risks.

An interview with the Director of Nursing on

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F 689	Continued From page 16 9/25/24 at 8:51 AM revealed she had assessed the current residents for elopement risks. She also will assess new admissions for elopement risks. An interview with the Maintenance Director on 9/24/24 at 11:43 AM revealed he had received education about resident elopement and wandering residents. He stated he will be conducting twice weekly window audits and weekly elopement drills. The facility's completion date for the corrective action plan of 9/20/24 was validated.	F 689		